

Debate & Analysis

The benefits of multidisciplinary safeguarding meetings

VULNERABLE CHILDREN

GPs are in a prime position to identify vulnerable children. Treating whole families over long periods of time, we are rewarded with valuable insights into the difficulties that some children face. However, we only see the lives of children in 10-minute snapshots and must recognise that the influences on a child's wellbeing are many and varied. This problem is compounded by the fact that we rarely see into the homes of young families, with domiciliary visits being largely reserved for frail older people and those with multiple morbidities. We must therefore draw on the wider healthcare team to obtain as full a picture as possible of a child's life if we are to recognise those in need.

To address this need the Wyre Forest clinical commissioning group (CCG) has commissioned a Safeguarding Children Local Enhanced Service (LES). Practices are funded to hold regular multidisciplinary safeguarding meetings.

BACKGROUND

A need to share

In recent years there have been a number of tragic cases of child deaths following prolonged periods of abuse. These have been well publicised in the media. The serious case review conducted by Haringey Local Safeguarding Children Board in the wake of the Baby Peter case refers to poor communication between the GP and health visitor. The report states that inaction on the part of the GP resulted from misguided assumptions that other professionals were in a better position to act on concerns that had been raised regarding the child's care.¹ Following the death of Victoria Climbié in 2000, Lord Laming's inquiry highlighted the important role that a GP must play in the distribution of information that might be important in determining if a child is vulnerable.² Improvement in documentation may also be necessary; Woodman *et al* report the under-recording of maltreatment-related concerns in GP-held medical records. Their article proposes standardisation of the terminology used when child maltreatment is suspected.³

Guidance for doctors

The government document *Working Together to Safeguard Children* describes

effective information sharing as a vital element of early intervention and safeguarding.⁴ Two GMC documents, *Protecting children and young people* and *0–18 years: guidance for all doctors*, guide doctors through the practicalities and importance of information sharing.^{5,6} The latter publication advises clinicians that a risk may only reveal itself when a group of professionals share their individual low-level concerns. This point is further made within the Royal College of General Practitioners' safeguarding toolkit, which refers to the 'jigsaw' of child protection that is only complete when agencies share information together. The same document also informs GPs of their statutory duty to cooperate with other agencies as specified in the Children Acts of 1989 and 2004 (section 27 and section 11 respectively).⁷ Cooperation, however, does not seem to go far enough and perhaps collaboration is a better description of how services should interact.⁸

The Wyre Forest

The Wyre Forest is a region in north Worcestershire with a population size of 98 100 and an estimated 19 000 children.⁹ Within the region, deprivation is lower than the national average; however, about 3300 children live in poverty.¹⁰ The Wyre Forest CCG represents the 12 practices located broadly within this area.

INITIATION OF THE ENHANCED SERVICE

The doctors of one Wyre Forest practice were aware that allied health professionals held valuable information regarding children and their families but there was no robust mechanism by which this could be shared. Thus, the local school nurse and representatives from the health visiting team were invited to attend regular meetings at the surgery. Positive feedback from those attending these initial meetings prompted the decision to encourage other

practices to adopt the same approach. This additional work was subsequently formally incentivised through a new enhanced service. The LES was originally commissioned by the CCG in July 2012.

SAFEGUARDING MEETINGS

To satisfy the requirements of the LES, practices must hold meetings on at least six occasions throughout the year. The attendees should include a GP, a health visitor, and a school nurse. The team is supported by a member of the practice administration staff who is responsible for compiling the agenda and documenting the discussions. The minutes that are generated are made available to the practice clinical team. An alert is added to the computer-held record of any child who is discussed, so if they subsequently attend the practice the consulting clinician is signposted to refer to the minutes for further details. LESs came to an end in April 2014; the meetings, however, have continued as part of a service specification within the standard NHS contract.

During the enhanced service's first operational year, eight of the 12 practices enlisted. All but one managed to hold sufficient meetings and were awarded payments. In its second year, 11 out of the 12 practices were participating in the LES.

FEEDBACK FROM PROFESSIONALS

In order to determine whether the meetings were felt to be beneficial, a web-based survey (Appendix 1) was sent out to the managers of the 11 participating practices. They were asked to forward it to those staff members who attended the meetings. It was also sent to the 17 health visitors and six school nurses working within the Wyre Forest. Twenty-four responses were received: 42% of these came from GPs, 25% from health visitors, and 25% from school nurses. All responders stated that they found the meetings useful. The main

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rationale for their positive responses were that the meeting provided a forum to share concerns and to pool relevant information from different professionals. All responders felt that the meetings had improved communication between members of the multidisciplinary team and 83% reported an improvement in professional relationships. In terms of problems encountered, 39% reported difficulty in arranging for all relevant professionals to be available to attend and 8.7% had encountered difficulty with writing and distributing the minutes.

DISCUSSION

The meetings have clearly been well received by those involved in the delivery of health services to children and their families. The aim of the meetings is to improve communications between teams so that families in need of support are identified at an earlier stage.

The impact of the safeguarding meetings will be hard to quantify. The number and type of children's services interventions could be a reasonable outcome measure. If the number of children referred to social services in the year prior to the commissioning of the LES (2012) were compared with the same data 5 years later, a reduction in referrals may be demonstrated. Conversely, it may be that the improved recognition of vulnerable children will lead to more referrals. However, it is anticipated that as a result of the earlier interventions a smaller proportion of these would reach the threshold for child protection procedures.

The Wyre Forest CCG is relatively small and its board members engage well with the healthcare professionals it represents. Having a small local organisation such as this at the helm of healthcare delivery made the proposition of a safeguarding LES relatively easy to see through to an operational stage. For similar projects to be successful in other CCGs, the board members will need to be open to suggestions of service redesign proposed by their membership and have the necessary infrastructure to support GPs in carrying out the additional work.

As GPs we have a responsibility to every

child we meet during our clinical practice to be vigilant for signs that they may be in need of extra support. This is a burden of responsibility too great to be borne by doctors alone; safeguarding meetings allow this responsibility to be shared and have the potential to improve the lives of the children in our care.

Tristan Brodie,

GP, Stourport Health Centre, Stourport-on-Severn, Worcestershire.

Sarah Knight,

Clinical Development Manager, NHS Wyre Forest Clinical Commissioning Group, Locality Office, Kidderminster Health Centre, Kidderminster.

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Provenance

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ADDRESS FOR CORRESPONDENCE

Tristan Brodie

Stourport Health Centre, Worcester Street, Stourport-on-Severn, Worcestershire, DY13 8EH.

E-mail: tristan.brodie@nhs.net

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Appendix 1. Web-based survey questions circulated to health professionals who regularly attend safeguarding meetings

- 1. Do you hold Safeguarding LES meetings? If so, how often?**
Do not hold them / Every 2 weeks/ Every 4 weeks / Every 6 weeks / Every 8 weeks / Every 10 weeks / Other (please specify)
- 2. What is your professional background?**
GP / Practice nurse / Health visitor / School nurse / Other (please specify)
- 3. Do you think any other professional should be invited to these meeting?**
Yes (and if yes please state who) / No
- 4. How do you select children for inclusion in the Safeguarding LES meeting?**
Clinical judgement / Referral from other professional / Please state any other method
- 5. Has the administration of meetings been a problem? If so, please identify where the difficulties have arisen:**
Arranging the meetings with all professionals / Booking rooms / Writing minutes and sending out / No issues
- 6. How many children do you discuss at each meeting?**
0–10 / 11–20 / 21–30 / 31–40 / 41–50 / 51–60 / >60
- 7. Do you feel these meetings are useful?**
Yes / No
- 8. If you think these meetings are useful? Please indicate why. If you do not think they are useful, please indicate why in the extra box.**
Share concerns about the child / Good method to pool information from different professionals / May prompt a referral to another agency / May prompt a home visit / The responsibility is shared with a bigger team / Other (please specify)
- 9. Do you feel that the meeting has improved other issues such as:**
Data sharing on EMIS using EMIS flag / Communication with other members of the multidisciplinary team (MDT) / Professional relationships with other members of the MDT / A positive impact on the care provided to vulnerable children and families / Anything else (please specify)?
- 10. Do you feel the LES should be changed/amended? Or are there any other comments you would like to make? Please make any further comments below. We are reviewing this LES and your feedback would be extremely useful.**